

333015

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

85 3211

1-  
FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	20. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR	
			EVELYN	BELL	CREIGHTON	11	14	85		10:55 A	
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR	
FEMALE		WHITE		MONTH	DAY	YEAR	79			IF UNDER 24 HRS	
7a. BIRTHPLACE (COUNTRY) Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH WORCESTER			MD.	
10. CITY OR TOWN OF DEATH BERLIN, MD.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) BERLIN NURSING HOME			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE			12b. KIND OF BUSINESS OR INDUSTRY			
13. STATE MD.		14. CITY OR TOWN Dor.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE unk. 21613				
14. FATHER'S NAME FIRST George		MIDDLE	LAST Henry	15. MOTHER'S MAIDEN NAME FIRST Emma			MIDDLE	LAST Frazier			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 413-22-5252		17. INFORMANT			ADDRESS Rt. 2 Box 258 Emerson Creighton Jr. Parsonsburg Md.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>acute MI</i>											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
DUE TO, OR AS A CONSEQUENCE OF (b) <i>DJUD</i>											
DUE TO, OR AS A CONSEQUENCE OF (c) <i>Dye</i>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) <i>Jewell</i>		21f. LOCATION STREET		CITY OR TOWN	COUNTY	STATE	<i>85</i>		
22a. I certify that (I) (this hospital) attended the deceased from <i>Nov 14</i> , 19 <i>85</i> , to <i>Nov.</i> , 19 <i>85</i> , that (I) (we) last saw the deceased alive on <i>Nov 14</i> , 19 <i>85</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>John Arthe</i>		22c. DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/>		MEDICAL DIRECTOR <input type="checkbox"/>	STAFF PHYSICIAN <input type="checkbox"/>	22d. DATE SIGNED <i>11-14-85</i>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>F. G. Arthe</i>		22e. ADDRESS <i>3 Bay St - Berlin 21811</i>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial		23b. DATE 11/17/85		23c. NAME OF CEMETERY OR CREMATORIAL E. NEW MARKET CEM.			23d. LOCATION CITY OR TOWN E. NEW MARKET			COUNTY DOR.	STATE MD.
24. FUNERAL DIRECTOR <i>THOMAS FUNERAL HOME</i>		ADDRESS <i>CAMBRIDGE MD.</i>			25a. DATE REC'D. BY REGISTRAR <i>NOV 21 1985</i>			25b. REGISTRAR'S SIGNATURE <i>Julia Davidson Pendall</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be submitted within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician in Part 1, it should be detached from Part 1 and sent to the funeral director. Then please remove carbon paper. Part 1 and Part 2 should be detached for use at the burial or funeral permit. Then please remove carbon paper. Part 1 and Part 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 showing any injury, or other traumatic event, the medical examiner must be notified immediately.

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PRINCIPAL LETTERS. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORMS P.M. 3, RETAIN PAGE 5 FOR YOUR FILES.

TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 4 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND 21201, PRIOR TO BURIAL, CREMATION, OR REMOVAL.

85 32772

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- STATE REGISTRAR

I. DECEASED NAME (TYPE OR PRINT)			FIRST Anna	MIDDLE Mae	LAST Haggins	2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/>	MONTH 11	DAY 3	YEAR 1985	2b. HOUR 6 a.m.
3. SEX <input checked="" type="checkbox"/> F	4. RACE Black	5. DATE OF BIRTH MONTH DAY YEAR 8 30 47	6. AGE (IN YEARS LAST BIRTHDAY) 38 yrs.	IF UNDER 1 YR. MONTHS 0	IF UNDER 24 HRS. DAYS 0	HOURS 0	MIN 0		2d. HOUR 8 a.m.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Del.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED		9. BALTIMORE CITY OR COUNTY OF DEATH worcester				
10. CITY OR TOWN OF DEATH Newark Md.		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Hwy 113 South Newark Md.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Cook		12b. KIND OF BUSINESS OR INDUSTRY Seafood		
13a. STATE Md.		13b. COUNTY Worcester		13c. CITY OR TOWN Berlin		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS PoB 264 Stocton Md.			
14. FATHER'S NAME FIRST Clarence		MIDDLE N.	LAST Whaley	15. MOTHER'S MAIDEN NAME FIRST Edna		MIDDLE Mae	LAST Whaley			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 216-48-5176		17. INFORMANT Robert Whaley		ADDRESS Salisbury Md.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 8/99 IMMEDIATE CAUSE (a)		cardiac arrest								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last.		DUE TO, OR AS A CONSEQUENCE OF injurys								
(b)		DUE TO, OR AS A CONSEQUENCE OF								
(c)		autoaccident								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY	STATE	
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE 										DATE SIGNED 11/3/85
EXAMINER'S NAME (TYPE OR PRINT)		TITLE (SPECIFY) M.D. <b>deputy</b> MEDICAL EXAMINER								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE Burial 11-9-85		23c. NAME OF CEMETERY OR CREMATORIAL Berlin Ch Cemetery		23d. LOCATION CITY OR TOWN Berlin		COUNTY	STATE	
24. FUNERAL DIRECTOR NAME Fooks Funeral Home		ADDRESS Salisbury Md.		25a. DATE REC'D. BY REGISTRAR Nov 06 1985		25b. REGISTRAR'S SIGNATURE 				

EXOSCE

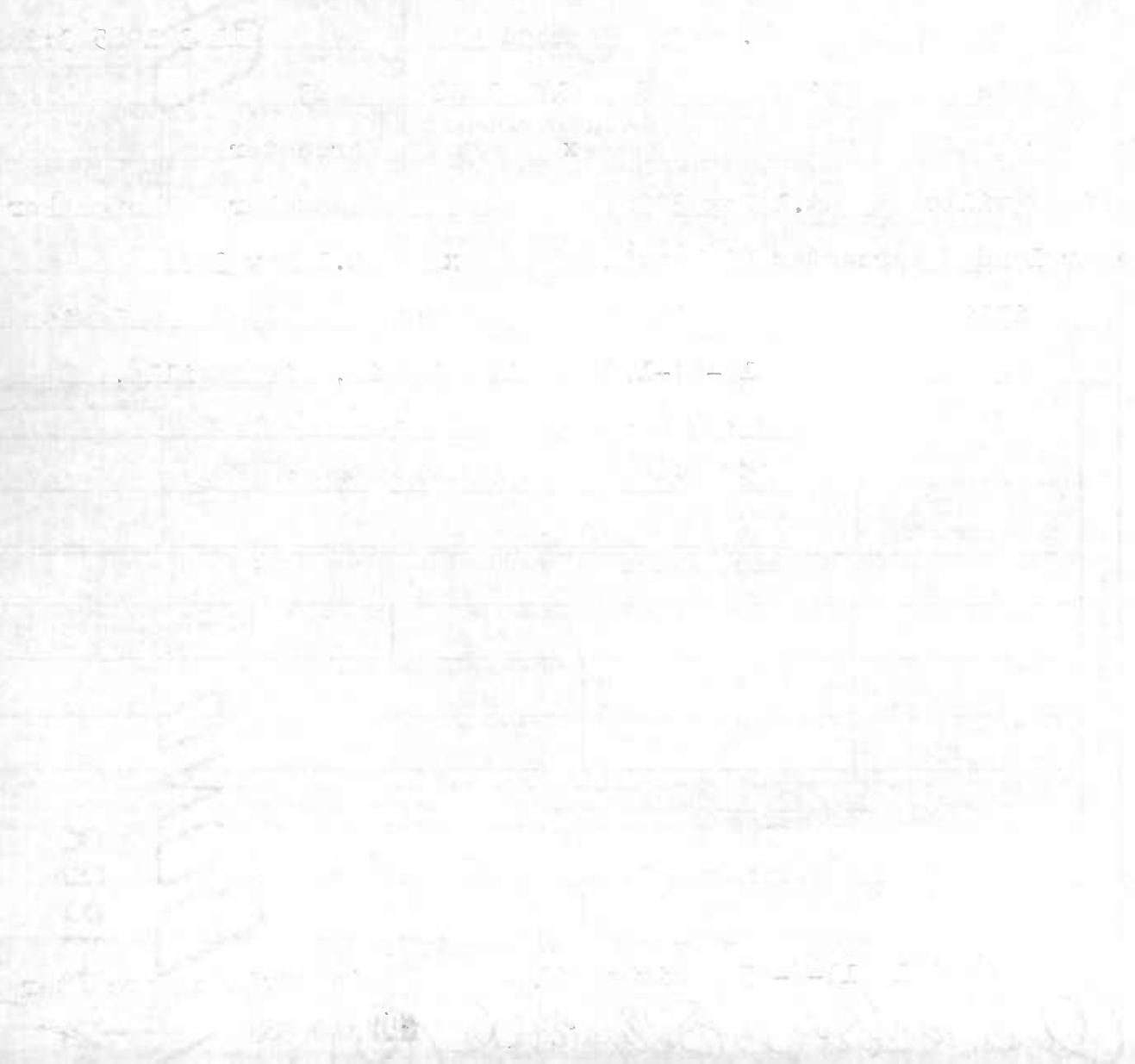
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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.				
1 - FOR STATE REGISTRAR			2a. DATE OF DEATH MONTH DAY YEAR							2b. HOUR				
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE			LAST		11 3 1985			3:30 PM			
12 Viola M. Hammond														
3. SEX			4. RACE			5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.			
Female			White			5 17 1902		83			YRS.			
7a. BIRTHPLACE COUNTRY			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			MD.			
Maryland			USA					Worcester						
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)							12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY	
Bishopville			Rt. 1 Box 309							Homemaker			Homemaker	
13a. STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS			21813		
Maryland			Worcester		Bishopville				Rt. 1 Box 309					
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST											
William Quillen			Nancy										Lewis	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT		ADDRESS						
No			219-44-1769			Evelyn Godwin, Bishopville, MD								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) RESPIRATORY ARREST													APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DUE TO, OR AS A CONSEQUENCE OF (b) PRIMARY HYPERPARATHYROID														
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.														
DUE TO, OR AS A CONSEQUENCE OF (c) HYPERCALCEMIA														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)														
19a. MEDICAL CERTIFICATION			19b. DATE OF OPERATION			19c. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
									YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE								
22a. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on 10/28/85, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.														
22b. SIGNATURE						DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)												11/5/85		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL BISHOPVILLE			23d. LOCATION CITY OR TOWN COUNTY STATE			23e. DATE REC'D. BY REGISTRAR		
Burial			11-6-85						BISHOPVILLE Worcester MD			NOV 06 1985		
24. FUNERAL DIRECTOR NAME			ADDRESS											
Charles W. White			Selbyville, DE											
25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE											

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or if item 18 shows any injury, or other traumatic event, the medical examiner must be notified once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.													
1. FOR STATE REGISTRAR			2a. DATE OF DEATH MONTH DAY YEAR							2b. HOUR													
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	November 10, 1985							2 P M										
Lemuel James Harmon																							
3. SEX			4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)				IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.											
Male			Black		July 13, 1921			64				YRS.											
7a. BIRTHPLACE COUNTRY			7b. CITIZEN OF WHAT COUNTRY?		8			9. BALTIMORE CITY OR COUNTY OF DEATH Worcester				MD.											
Maryland			USA		MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			10. CITY OR TOWN OF DEATH Snow Hill				11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 201 Commerce Street				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Laborer				12b. KIND OF BUSINESS OR INDUSTRY Poultry			
13a. STATE Maryland			13b. COUNTY Worcester		13c. CITY OR TOWN Snow Hill			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				13e. STREET ADDRESS 201 Commerce St. / 21863											
14. FATHER'S NAME FIRST Arthur			MIDDLE	LAST	15. MOTHER'S MAIDEN NAME Beulah			16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No				16b. SOCIAL SECURITY NO. 215 20 0253				17. INFORMANT ADDRESS Delores V. Waters, Snow Hill, Maryland							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ARTERIOSCLEROSIS FAILURE</u>			18. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 month</u>																				
Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last.			18. DUE TO, OR AS A CONSEQUENCE OF (b) <u>CHEMICAL ALCOHOLISM</u>			18. DUE TO, OR AS A CONSEQUENCE OF (c)			18. PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED							20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>											
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)																	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY	STATE											
22a. I certify that (I) (this hospital) attended the deceased from <u>11/8/85</u> 19_____ to <u>11/16/85</u> 19_____, that (I) <input type="checkbox"/> last saw the deceased alive on <u>11/8/85</u> 19_____ and that in (my) <input type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above, (I) <input type="checkbox"/> did <input type="checkbox"/> did not view the body after death.																							
22b. SIGNATURE <u>Robert C. La Mar, M.D.</u>						22c. DEGREE			22d. DATE SIGNED <u>11-13-85</u>														
22e. PHYSICIAN'S NAME (TYPE OR PRINT) ROBERT C. LA MAR, M.D.						22f. ADDRESS 104 N. Bay St. Snow Hill, Md. 21863																	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 11/16/85			23c. NAME OF CEMETERY OR CREMATORIAL Mt. Wesley			23d. LOCATION CITY OR TOWN Snow Hill, Maryland				23e. COUNTY		STATE								
24. FUNERAL DIRECTOR NAME Norman F. Dennis, Snow Hill, Maryland						25a. DATE REC'D. BY REGISTRAR NOV 19 1985			25b. REGISTRAR'S SIGNATURE <u>Julia Dennis, Registrar</u>														

SCONES

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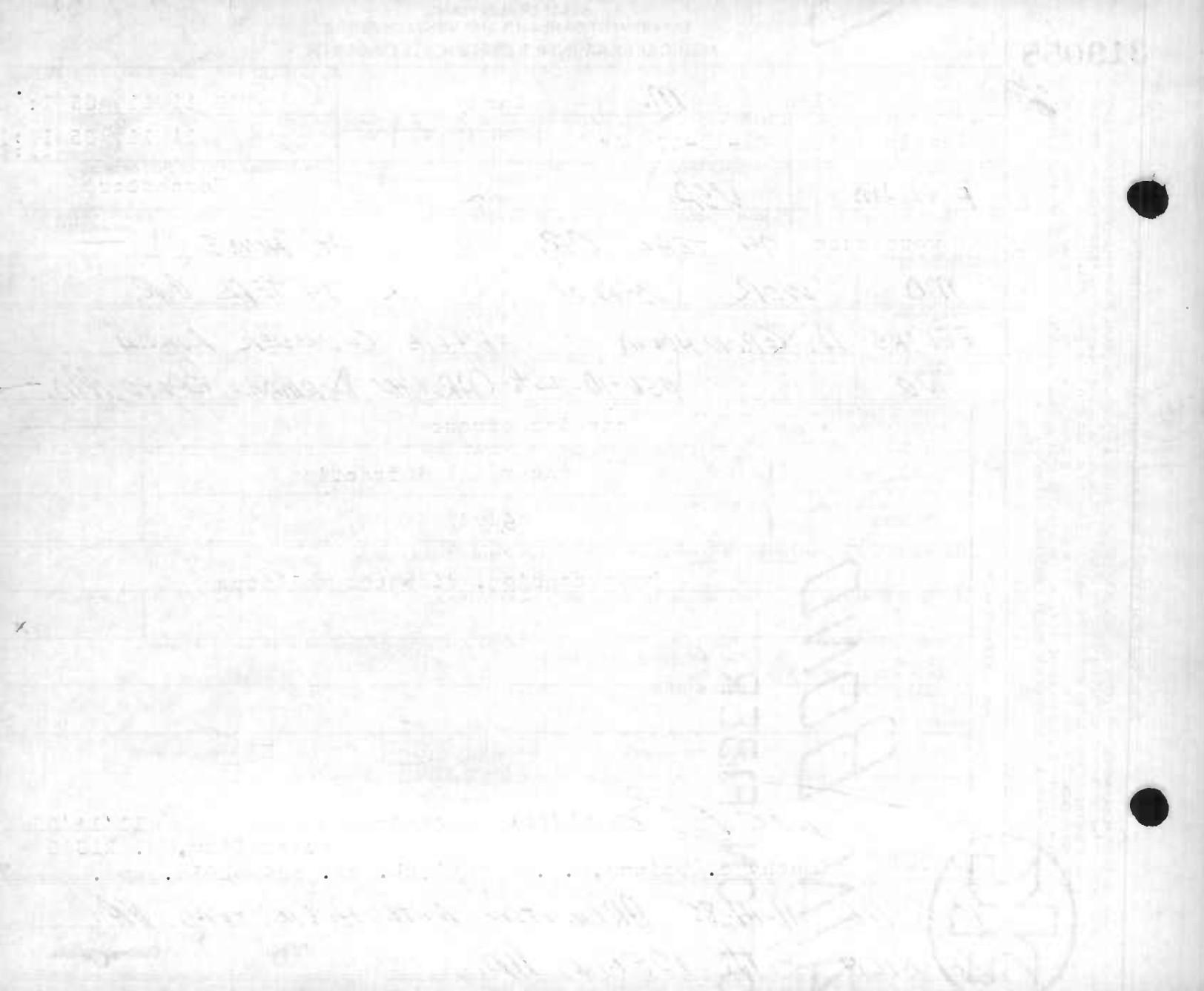
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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- STATE REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)			FIRST <b>Helen</b>	MIDDLE <b>m.</b>	LAST <b>Hartye</b>	2a. DATE OF DEATH ESTL. MATED <b>X 11 11 1985</b>	MONTH <b>11</b>	DAY <b>11</b>	YEAR <b>1985</b>	2b. HOUR a.m. <b>1:00</b>			
3. SEX <b>female</b>	4. RACE <b>white</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>08-15-17</b>	6. AGE (IN YEARS LAST BIRTHDAY) YRS. <b>68</b>	IF UNDER 1 YR. MONTHS <b>0</b>	IF UNDER 24 HRS. DAYS <b>0</b>	IF HOURS <b>0</b>	IF MIN. <b>0</b>	2c. DATE PRONOUNCED DEAD <b>11 11 85</b>	MONTH <b>11</b>	DAY <b>11</b>	YEAR <b>1985</b>	2d. HOUR 11:11	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>FINLAND</b>			7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>			8. MARRIED NEVER MARRIED WIDOWED DIVORCED <b>WIDOWED</b>			9. BALTIMORE CITY OR COUNTY OF DEATH <b>Worcester</b>				
10. CITY OR TOWN OF DEATH <b>worcester</b>			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>74 TEAL CR.</b>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>AT HOME</b>			12b. KIND OF BUSINESS OR INDUSTRY				
13a. STATE <b>MD</b>	13b. COUNTY <b>WOR</b>	13c. CITY OR TOWN <b>BERLM</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>74 TEAL CR. 21811</b>								
14. FATHER'S NAME FIRST <b>FELIKS</b>			MIDDLE <b>A.</b>	LAST <b>GROHOLM</b>	15. MOTHER'S MAIDEN NAME FIRST <b>ILLIE</b>			MIDDLE <b>GUNNER</b>	LAST <b>LINDA</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>NO</b>			16b. SOCIAL SECURITY NO. <b>056-10-2546</b>			17. INFORMANT ADDRESS <b>Carolyn Dorman Barto, Jr.</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)). PART I DEATH WAS CAUSED BY: <b>cardiac arrest</b> IMMEDIATE CAUSE (a) DUE TO, OR AS A CONSEQUENCE OF <b>myocardial infarction</b> (b) DUE TO, OR AS A CONSEQUENCE OF <b>ascvd.</b> (c)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS (CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)). <b>hypertension, diabetes mellitus</b>													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY?				
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN	COUNTY	STATE		
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>												DATE SIGNED <b>11/11/85</b>	
ACTUAL SIGNATURE <i>Tim Bainum</i> TITLE (SPECIFY) <b>deputy MEDICAL EXAMINER</b>													
EXAMINER'S NAME (TYPE OR PRINT) <b>timothy e. bainum, m.d.</b>			ADDRESS <b>16th st. and phila. ave.</b>			23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>			23b. DATE <b>11-14-85</b>	23c. NAME OF CEMETERY OR CREMATORIUM <b>ARLINGTON NATL</b>	23d. LOCATION CITY/TOWN <b>ARLINGTON, VA.</b>	COUNTY	STATE
24. FUNERAL DIRECTOR NAME <b>J. RICH F. H. BERK, MD.</b>			ADDRESS			25a. DATE REC'D. BY REGISTRAR <b>NOV 13 1985</b>			25b. REGISTRAR'S SIGNATURE <i>John P. O'Dell</i>				



325074

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, an other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 3276			
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR	
LOUISE H. NORTHAM						November 10, 1985						M	
3. SEX			4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6 AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 24 HRS		
female			white		Jan. 25, 1925			60			MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?		8			9. BALTIMORE CITY OR COUNTY OF DEATH					
Maryland			USA		MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>			Worcester					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY				
Pocomoke			215 Walnut Street			City Clerk-Town of Pocomoke			21801				
13a. STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS				
Maryland			Worcester		Pocomoke		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		215 Walnut Street				
14. FATHER'S NAME			FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME			16. SOCIAL SECURITY NO.			ADDRESS	
George			H.		Henderson, Sr.	Margaret			219-14-4787			Route #3, Box 416B E. Thomas Northam Pocomoke City, Md.	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
no			219-14-4787			E. Thomas Northam Pocomoke City, Md.			Carcinoma of Lung				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			DUE TO, OR AS A CONSEQUENCE OF (b)			DUE TO, OR AS A CONSEQUENCE OF (c)							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?				
19b. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			YES <input type="checkbox"/> NO <input type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY	STATE
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE <i>Paul R. Fleury</i>			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 11/12/85				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>PAUL R Fleury</i>			22e. ADDRESS 305 Tenth St Pocomoke City, Md.										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 11/12/85			23c. NAME OF CEMETERY OR CREMATORIAL Salem Methodist Cem.			23d. LOCATION CITY OR TOWN Pocomoke			COUNTY	STATE Worcester Md.
24. FUNERAL DIRECTOR NAME <i>Scott M. Nelson</i>			ADDRESS Pocomoke City, Md.			25a. DATE REC'D. BY REGISTRAR Nov. 15 1985			25b. REGISTRAR'S SIGNATURE <i>John Davidson Rendell</i>				

1-70-28

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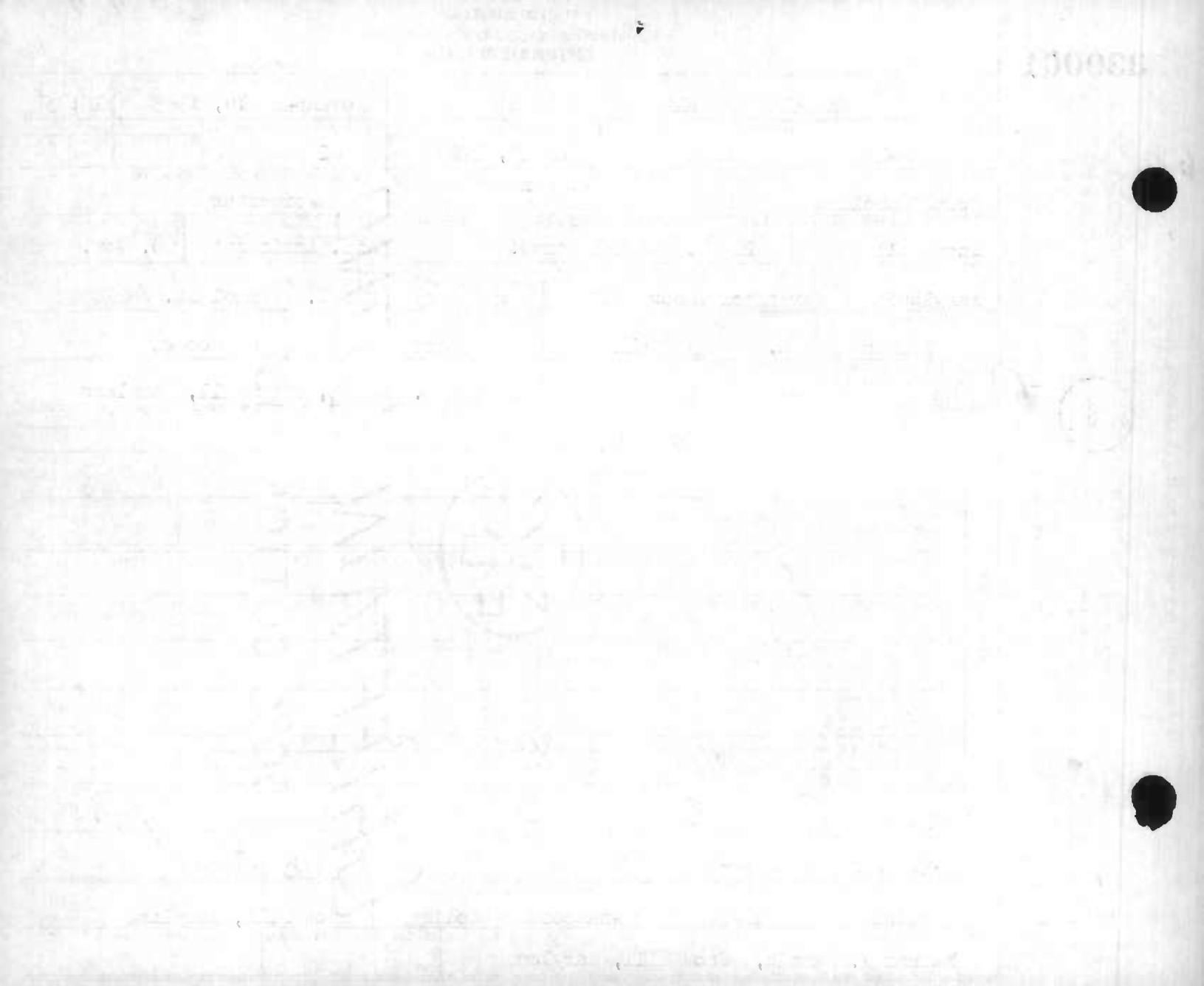
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be detached for use as the burial transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or entombment.

IMPORTANT: If item 21 is marked or if item 18 shows any injury, or other traumatic event, the medical examiner shall be pained of once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO. 8532777						
1 - FOR STATE REGISTRAR			2a. DATE OF DEATH MONTH DAY YEAR November 14, 1985									2b. HOUR 10:45 P M						
I. DECEASED NAME (TYPE OR PRINT)			FIRST Rachel	MIDDLE Hall	LAST Perdue			5. DATE OF BIRTH MONTH DAY YEAR May 17, 1923			6. AGE (IN YEARS LAST BIRTHDAY) 62 YRS.			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.		
3. SEX Female			4. RACE White															
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) North Carolina			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Worcester MD.									
10. CITY OR TOWN OF DEATH Snow Hill			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 218 W. Federal Street						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Adm. Assistant			12b. KIND OF BUSINESS OR INDUSTRY Co. Gov.						
13a. STATE Maryland			13b. COUNTY Worcester			13c. CITY OR TOWN Snow Hill			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS 218 W. Federal St. / 21863						
14. FATHER'S NAME FIRST Norman			MIDDLE E.	LAST Hall			15. MOTHER'S MAIDEN NAME FIRST Daisey			MIDDLE	LAST Hooper							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. -----			17. INFORMANT			ADDRESS									
			219 34 4045			Edward A. Perdue, Snow Hill, Maryland												
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Amyloidosis</i>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, lost. (b)																		
DUE TO, OR AS A CONSEQUENCE OF (c)																		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																		
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b. PART 1 OR PART 2)												
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN	COUNTY	STATE							
22a. I certify that (I) (this hospital) attended the deceased from <i>10/13</i> to <i>10/15/85</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated saw the deceased alive on <i>10/13</i> 19 <i>85</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												22c. DATE SIGNED <i>11/15/85</i>						
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>DAVID E. COOKE, MD</i>			22e. ADDRESS <i>1300 S Division St Salisbury, MD 21851</i>			DEGREE <i>MD</i>			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 11/18/85			23c. NAME OF CEMETERY OR CREMATORIAL Whatcoat Methodist			23d. LOCATION CITY OR TOWN Snow Hill, Maryland			COUNTY	STATE					
24. FUNERAL DIRECTOR NAME <i>Norman F. Dennis, Snow Hill, Maryland</i>						25a. DATE REC'D. BY REGISTRAR <i>Nov 21 1985</i>			25b. REGISTRAR'S SIGNATURE									
DHMH-16 30M 2/80 (VRA 15, 4)																		

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**TO MEDICAL EXAMINER:** THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN BLOCK CAPITAL LETTERS. PAGE 1, 2, AND 3 TO THE FUNERAL DIRECTOR.  
**PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3, RETAIN PAGE 5 FOR YOUR FILES.**  
**TO FUNERAL DIRECTOR:** PAGE 3 SHOULD BE USED AS A BURIAL TRANSFER PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 WATKINS STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 3277	
1- STATE REGISTRAR			2a DATE KNOWN <input type="checkbox"/> MONTH DAY YEAR OF ESTI- DEATH MATED <input checked="" type="checkbox"/> 11 8 1985 9:30 AM										
1 DECEASED NAME (TYPE OR PRINT)		FIRST William	MIDDLE Thomas	LAST Phillips, Jr.	2b HOUR 2d HOUR								
3. SEX male		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR 04-04-44		6. AGE (IN YEARS LAST BIRTHDAY) 41 YRS		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.			
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. DATE PRONOUNCED DEAD MONTH DAY YEAR 11 8 1985 9:30 AM				BALTIMORE CITY OR COUNTY OF DEATH worcester			
10 CITY OR TOWN OF DEATH snowhill		11 NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Mt. Olive Church Road				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Unemployed				12b KIND OF BUSINESS OR INDUSTRY			
13a STATE Md.		13b. COUNTY Worcester		13c. CITY OR TOWN Snow Hill		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS Mt. Olive Church Rd. 21863					
14 FATHER'S NAME FIRST William		MIDDLE T.	LAST Phillips	15. MOTHER'S MAIDEN NAME FIRST Louise		MIDDLE	LAST Thornes						
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 217-42-5726		17. INFORMANT Mrs. Louise Phillips		ADDRESS Burd Ave Parsonsburg; Md.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY:  IMMEDIATE CAUSE (a) cardiac arrest  DUE TO, OR AS A CONSEQUENCE OF  Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.  (b) malnutrition, dehydration  DUE TO, OR AS A CONSEQUENCE OF  (c) cirrhosis of liver												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). chronic alcoholism													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?									20 AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN	COUNTY	STATE		
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE <i>timothy e. bainum</i>		TITLE (SPECIFY) M.D. deputy MEDICAL EXAMINER										DATE SIGNED 11/15/85	
EXAMINER'S NAME (TYPE OR PRINT) timothy e. bainum, m.d.		ADDRESS 16th. st. and phila, ave ocean city, md, 21842											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal		23b. DATE 11/15/85		23c. NAME OF CEMETERY OR CREMATORIAL Balto., Md.				23d. LOCATION CITY OR TOWN		COUNTY	STATE		
24. FUNERAL DIRECTOR NAME Anatomy Board		25a. DATE REC'D. BY REGISTRAR NOV 20 1985				25b. REGISTRAR'S SIGNATURE <i>Jane E. Bainum, M.D.</i>							
ADDRESS													

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TO HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 24 hours after death. Page 4 may be referred by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached to serve as the burial permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene either the Berlin, cremation, or removal.

WARNING: If Item 21 is marked in Item 18 there can only be one primary or other traumatic event, the immediate cause of death.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												
REG. NO. 52												
1. FOR STATE REGISTRAR			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR			
I. DECEASED NAME (TYPE OR PRINT)			Grayson Holland Quillen			11 20 85			6:00 AM			
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY) YRS.			IF UNDER 1 YEAR IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.		
Female		Caucasian		05 30 1903			82					
7a. BIRTHPLACE STATE OR FOREIGN COUNTRY		7b. CITIZEN OF WHAT COUNTRY?		8			9. BALTIMORE CITY OR COUNTY OF DEATH Worcester			MD.		
Maryland		U.S.A.		MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>								
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY				
Berlin		Box 352, Route 4			farmer							
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)												
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE			
Maryland		Worcester		Berlin					Box 352, Route 4, 21811			
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST									
Samuel T. Quillen			Virginia									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS								
NO		217-36-1491		Mrs. Florida V. Quillen, Box 352, Rt. 4, Berlin, MD 21811								
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>CEREBROVASCULAR ACCIDENT</u>												
DUE TO, OR AS A CONSEQUENCE OF (b) <u>ATHEROSCLEROTIC VASCULAR DISEASE</u>												
Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last.												
DUE TO, OR AS A CONSEQUENCE OF (c) <u>HYPERTENSION</u>												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR AM MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET _____ CITY OR TOWN _____ COUNTY _____ STATE _____							
22a. I certify that (I) (this hospital) attended the deceased from <u>8/28</u> , 19 <u>81</u> , to <u>11/20</u> , 19 <u>85</u> , that (we) last saw the deceased alive on <u>9/17</u> , 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death.												
22b. SIGNATURE <u>Paul A. Scott, MD</u>		DEGREE MD			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <u>11/21/85</u>				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>PAUL A. SCOTT, MD</u>		22e. ADDRESS <u>24 BROAD ST. BERLIN, MD,</u>										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 11/22/85		23c. NAME OF CEMETERY OR CREMATORIAL Sunset Memorial Pk			23d. LOCATION CITY OR TOWN Berlin Worcester MD					
24. FUNERAL DIRECTOR NAME <u>W. Kirk Burbage, 108 Wms St., Berlin</u>		ADDRESS <u>MD</u>			25a. DATE REC'D. BY REGISTRAR <u>11/22/85</u>			25b. REGISTRAR'S SIGNATURE <u>John Andrew Johnson</u>				
DHMH - 16 50M 4/83 (VRA 15, 4)												

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THE PRACTICAL  
METHOD OF  
MANUFACTURE

HARVEY LEWIS

6-78 date 10-3-88 file no.  
201211  
John H. Lewis  
100, 110, 120, 130, 140, 150, 160, 170, 180, 190, 200, 210, 220, 230, 240, 250, 260, 270, 280, 290, 300, 310, 320, 330, 340, 350, 360, 370, 380, 390, 400, 410, 420, 430, 440, 450, 460, 470, 480, 490, 500, 510, 520, 530, 540, 550, 560, 570, 580, 590, 600, 610, 620, 630, 640, 650, 660, 670, 680, 690, 700, 710, 720, 730, 740, 750, 760, 770, 780, 790, 800, 810, 820, 830, 840, 850, 860, 870, 880, 890, 900, 910, 920, 930, 940, 950, 960, 970, 980, 990, 1000, 1010, 1020, 1030, 1040, 1050, 1060, 1070, 1080, 1090, 1100, 1110, 1120, 1130, 1140, 1150, 1160, 1170, 1180, 1190, 1200, 1210, 1220, 1230, 1240, 1250, 1260, 1270, 1280, 1290, 1300, 1310, 1320, 1330, 1340, 1350, 1360, 1370, 1380, 1390, 1400, 1410, 1420, 1430, 1440, 1450, 1460, 1470, 1480, 1490, 1500, 1510, 1520, 1530, 1540, 1550, 1560, 1570, 1580, 1590, 1600, 1610, 1620, 1630, 1640, 1650, 1660, 1670, 1680, 1690, 1700, 1710, 1720, 1730, 1740, 1750, 1760, 1770, 1780, 1790, 1800, 1810, 1820, 1830, 1840, 1850, 1860, 1870, 1880, 1890, 1900, 1910, 1920, 1930, 1940, 1950, 1960, 1970, 1980, 1990, 2000, 2010, 2020, 2030, 2040, 2050, 2060, 2070, 2080, 2090, 2100, 2110, 2120, 2130, 2140, 2150, 2160, 2170, 2180, 2190, 2200, 2210, 2220, 2230, 2240, 2250, 2260, 2270, 2280, 2290, 2300, 2310, 2320, 2330, 2340, 2350, 2360, 2370, 2380, 2390, 2400, 2410, 2420, 2430, 2440, 2450, 2460, 2470, 2480, 2490, 2500, 2510, 2520, 2530, 2540, 2550, 2560, 2570, 2580, 2590, 2600, 2610, 2620, 2630, 2640, 2650, 2660, 2670, 2680, 2690, 2700, 2710, 2720, 2730, 2740, 2750, 2760, 2770, 2780, 2790, 2800, 2810, 2820, 2830, 2840, 2850, 2860, 2870, 2880, 2890, 2900, 2910, 2920, 2930, 2940, 2950, 2960, 2970, 2980, 2990, 3000, 3010, 3020, 3030, 3040, 3050, 3060, 3070, 3080, 3090, 3100, 3110, 3120, 3130, 3140, 3150, 3160, 3170, 3180, 3190, 3200, 3210, 3220, 3230, 3240, 3250, 3260, 3270, 3280, 3290, 3300, 3310, 3320, 3330, 3340, 3350, 3360, 3370, 3380, 3390, 3400, 3410, 3420, 3430, 3440, 3450, 3460, 3470, 3480, 3490, 3500, 3510, 3520, 3530, 3540, 3550, 3560, 3570, 3580, 3590, 3600, 3610, 3620, 3630, 3640, 3650, 3660, 3670, 3680, 3690, 3700, 3710, 3720, 3730, 3740, 3750, 3760, 3770, 3780, 3790, 3800, 3810, 3820, 3830, 3840, 3850, 3860, 3870, 3880, 3890, 3900, 3910, 3920, 3930, 3940, 3950, 3960, 3970, 3980, 3990, 4000, 4010, 4020, 4030, 4040, 4050, 4060, 4070, 4080, 4090, 4100, 4110, 4120, 4130, 4140, 4150, 4160, 4170, 4180, 4190, 4200, 4210, 4220, 4230, 4240, 4250, 4260, 4270, 4280, 4290, 4300, 4310, 4320, 4330, 4340, 4350, 4360, 4370, 4380, 4390, 4400, 4410, 4420, 4430, 4440, 4450, 4460, 4470, 4480, 4490, 4500, 4510, 4520, 4530, 4540, 4550, 4560, 4570, 4580, 4590, 4590, 4600, 4610, 4620, 4630, 4640, 4650, 4660, 4670, 4680, 4690, 4700, 4710, 4720, 4730, 4740, 4750, 4760, 4770, 4780, 4790, 4790, 4800, 4810, 4820, 4830, 4840, 4850, 4860, 4870, 4880, 4890, 4890, 4900, 4910, 4920, 4930, 4940, 4950, 4960, 4970, 4980, 4990, 4990, 5000, 5010, 5020, 5030, 5040, 5050, 5060, 5070, 5080, 5090, 5090, 5100, 5110, 5120, 5130, 5140, 5150, 5160, 5170, 5180, 5190, 5190, 5200, 5210, 5220, 5230, 5240, 5250, 5260, 5270, 5280, 5290, 5290, 5300, 5310, 5320, 5330, 5340, 5350, 5360, 5370, 5380, 5390, 5390, 5400, 5410, 5420, 5430, 5440, 5450, 5460, 5470, 5480, 5490, 5490, 5500, 5510, 5520, 5530, 5540, 5550, 5560, 5570, 5580, 5590, 5590, 5600, 5610, 5620, 5630, 5640, 5650, 5660, 5670, 5680, 5690, 5690, 5700, 5710, 5720, 5730, 5740, 5750, 5760, 5770, 5780, 5790, 5790, 5800, 5810, 5820, 5830, 5840, 5850, 5860, 5870, 5880, 5890, 5890, 5900, 5910, 5920, 5930, 5940, 5950, 5960, 5970, 5980, 5990, 5990, 6000, 6010, 6020, 6030, 6040, 6050, 6060, 6070, 6080, 6090, 6090, 6100, 6110, 6120, 6130, 6140, 6150, 6160, 6170, 6180, 6190, 6190, 6200, 6210, 6220, 6230, 6240, 6250, 6260, 6270, 6280, 6290, 6290, 6300, 6310, 6320, 6330, 6340, 6350, 6360, 6370, 6380, 6390, 6390, 6400, 6410, 6420, 6430, 6440, 6450, 6460, 6470, 6480, 6490, 6490, 6500, 6510, 6520, 6530, 6540, 6550, 6560, 6570, 6580, 6590, 6590, 6600, 6610, 6620, 6630, 6640, 6650, 6660, 6670, 6680, 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16160, 16170, 16180, 16190, 16190, 16200, 16210, 16220, 16230, 16240, 16250, 16260, 16270, 16280, 16290, 16290, 16300, 16310, 16320, 16330, 16340, 16350, 16360, 16370, 16380, 16380, 16390, 16390, 16400, 16410, 16420, 16430, 16440, 16450, 16460, 16470, 16480, 16490, 16490, 16500, 16510, 16520, 16530, 16540, 16550, 16560, 16570, 16580, 16590, 16590, 16600, 16610, 16620, 16630, 16640, 16650, 16660, 16670, 16680, 16690, 16690, 16700, 16710, 16720, 16730, 16740, 16750, 16760, 16770, 16780, 16790, 16790, 16800, 16810, 16820, 16830, 16840, 16850, 16860, 16870, 16880, 16890, 16890, 16900, 16910, 16920, 16930, 16940, 16950, 16960, 16970, 16980, 16980, 16990, 16990, 17000, 17010, 17020, 17030, 17040, 17050, 17060, 17070, 17080, 17090, 17090, 17100, 17110, 17120, 17130, 17140, 17150, 17160, 17170, 17180, 17190, 17190, 17200, 17210, 17220, 17230, 17240, 17250, 17260, 17270, 17280, 17290, 17290, 17300, 17310, 17320, 17330, 17340, 17350, 17360, 17370, 17380, 17380, 17390, 17390, 17400, 17410, 17420, 17430, 17440, 17450, 17460, 17470, 17480, 17490, 17490, 17500, 17510, 17520, 17530, 17540, 17550, 17560, 17570, 17580, 17590, 17590, 17600, 17610, 17620, 17630, 17640, 17650, 17660, 17670, 17680, 17690, 17690, 17700, 17710, 177



GARROLL, MARYLAND

BURIAL J1\50\52 WESTMINSTER CEMETERY

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the certificate be executed within 24 hours after death. Form 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be delivered for use at the burial or transit permit. Then phone the Bureau of Health and Mental Hygiene prior to burial, cremation, or removal. If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner should be notified.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					REG. NO.			
1 - STATE REGISTRAR	FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR
1. DECEASED NAME (TYPE OR PRINT)	Elinor	P	Robbins	November		23	1985	5:05 am
3. SEX	Female	4. RACE	White	5. DATE OF BIRTH	MONTH	DAY	YEAR	6. AGE (IN YEARS LAST BIRTHDAY)
				Aug.	20			81-82 yrs
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	Maryland	7b. CITIZEN OF WHAT COUNTRY?	United States	MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. BALTIMORE CITY OR COUNTY OF DEATH			
10. CITY OR TOWN OF DEATH	Berlin, Md.	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	Berlin Nursing Home	9. BOSTON CITY OR COUNTY OF DEATH				
13a. STATE	Maryland	13b. COUNTY	Worcester	13c. CITY OR TOWN	Berlin	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE	
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	RT. 3 Box 455, Berlin, Md. 21811			
14. FATHER'S NAME	William	MIDDLE	Cottingham	Powell	15. MOTHER'S MAIDEN NAME	MIDDLE	LAST	
					Olive		Johnson	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (IF YES, GIVE WAR OR DATES)	Unknown	16b. SOCIAL SECURITY NO.	214-07-9668-R9	17. INFORMANT	ADDRESS			
				Louis P. Robbins, Croft, Md. 21426				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio Resp. Failure</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH								
DUE TO, OR AS A CONSEQUENCE OF (b) <u>HTSVD</u> .								
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Hyp</u>								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)								
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
					YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET	CITY OR TOWN	COUNTY	STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>NOV-22-1985</u> to <u>NOV-20-1985</u> , that (I) (we) last saw the deceased alive on <u>NOV-22-1985</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE	DEGREE	22c. DATE SIGNED						
22d. PHYSICIAN'S NAME (TYPE OR PRINT)	Federico Arthes	22e. ADDRESS	3 Bay Street, Berlin, Md. 21811					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE 11-25-85	23c. NAME OF CEMETERY OR CREMATORIAL Whitescost Meth.	23d. LOCATION CITY OR TOWN	23e. COUNTY	23f. STATE			
24. FUNERAL DIRECTOR NAME	ADDRESS	25a. DATE REC'D. BY REGISTRAR DEC 02 1985	25b. REGISTRAR'S SIGNATURE					
Norman F. Dennis, Snow Hill, Md.			Norman F. Dennis					

352162



330008

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in full, it should be detached for use as the burial permit. Then please send to your funeral home. If you have any questions, call the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH													
REG. NO. 330008													
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR	
Walter					Steiner	11			12	85	3:00AM		
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS	
Male		White		MONTH	DAY	YEAR	62			MONTHS	DAYS	HOURS	MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			YRS.			
Pennsylvania		USA					Worcester			MD.			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY				
Berlin			RD#2, Box 544A Berlin, MD			Supervisor			General Motor				
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)													
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE				
Maryland		Worcester		Berlin					RD#2, Box 544A Berlin, MD				
14. FATHER'S NAME FIRST			MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST			MIDDLE	LAST				
John			Andrew	Steiner	Mildred					Kowlaski			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS				
Yes			WWII			193 12 4436 Marian Steiner			RD#2, Box 544A, Berlin, Maryland				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a))													
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.													
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Arteriosclerotic Cardiovascular Disease</i>													
DUE TO, OR AS A CONSEQUENCE OF (c)													
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH MINS													
YKS													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)								
21d. INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY	STATE		
22a. I certify that (I) (this hospital) attended the deceased from 19 10, to 11/12, 19 85, that (we) last saw the deceased alive on 11/7 19 85, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I/we) (did) (did not) view the body after death.													
22b. SIGNATURE <i>Donald M. Wood</i>													
22c. DEGREE <i>MD</i>													
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>													
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Donald M. Wood													
22e. ADDRESS Locust & Quincy St's., Salisbury, MD													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE 11/14/85		23c. NAME OF CEMETERY OR CREMATORIAL Sunset Memorial			23d. LOCATION CITY OR TOWN Berlin, Worcester		COUNTY	STATE			
Burial													
24. FUNERAL DIRECTOR NAME W. Kirk Burbage		ADDRESS Berlin, MD 21811		108 Williams st.			25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE				
							NOV 19 1985		<i>Sister Davidson-Burbage</i>				

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

1 - FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME <b>Mary E. Tyler</b>			2a DATE OF DEATH <b>11 26 85</b>	MONTH YEAR	DAY	YEAR	2b HOUR <b>8:30pM</b>	
3. SEX <b>Female</b>		4 RACE <b>Caucasian</b>	5. DATE OF BIRTH <b>11 04 1891</b>			6 AGE (IN YEARS LAST BIRTHDAY) <b>94</b>	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN.
7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Virginia</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH <b>Worcester</b>
10 CITY OR TOWN OF DEATH <b>Pocomoke City</b>		11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Hartley Hall Nursing Home</b>			12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Senmstress</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>Labor</b>
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Somerset</b>		13c. CITY OR TOWN <b>Crisfield</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>Box 379 Crisfield, Md. 21817</b>
14. FATHER'S NAME FIRST <b>John</b>		MIDDLE <b>7</b>	LAST <b>Dize</b>		15 MOTHER'S MAIDEN NAME FIRST <b>Julie</b>		MIDDLE <b>CROCKETT</b>	LAST <b>Dize</b>
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR NO OR UNKNOWN) <b>no</b>		16b. SOCIAL SECURITY NO. <b>212-10-4432</b>			17 INFORMANT <b>Mrs. Clara Einely Crisfield, Md.</b>		ADDRESS	
18 CAUSE OF DEATH (Enter only one cause per line for 1a), (b), and (c) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>CANCER</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>EMBOLI TO ④ FOOT</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>ASCVD</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 wk.</b>								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY STATE
22a. I certify that (1) <b>this hospital</b> attended the deceased from <b>SEPT 19 85</b> to <b>Nov. 26 19 85</b> , that (2) (we) lost saw the deceased alive on <b>Nov. 25 19 85</b> , and that in <b>my</b> (our) opinion death occurred on the date and hour and from the causes stated above. (3) (we) did not view the body after death.								
22b. SIGNATURE <b>Robert Allen</b>		22c. DEGREE <b>MD.</b>		22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>		22e. DATE SIGNED <b>11/27/85</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>ROBERT ALLEN</b>		22e. ADDRESS <b>305 10th St., Pocomoke City, Md. 21851</b>						
23a. BURIAL, CREMATION, REMOVAL (ITEM #1) <b>Burial</b>		23b. DATE <b>11/29/85</b>		23c. NAME OF CEMETERY OR CREMATORIAL <b>Sunnyridge</b>		23d. LOCATION CITY OR TOWN <b>Crisfield Somerset Md.</b>		
24. FUNERAL DIRECTOR NAME <b>Angela C. Steling</b>		ADDRESS <b>Confidence Md.</b>		25a. DATE REC'D. BY REGISTRAR <b>DEC 02 1985</b>		25b. REGISTRAR'S SIGNATURE <b>JULIA L. PARKER</b>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be resubmitted by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be detached for use as the burial/transit permit. This page is to be retained by the funeral director. Page 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as having any injury, or other significant event, no medical examination must be conducted before

Category

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and certified filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper from page 2 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner may be notified at once.

336094

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 5 3 2 7 8 4

REG. NO.

1 FOR STATE REGISTRAR		2a. DATE OF DEATH MONTH DAY YEAR										2b. HOUR							
1. DECEASED NAME FIRST MIDDLE LAST		11 20 1985										6 M							
2. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS									
				1-17-31		53		MONTHS DAYS		HOURS MIN.									
7a. BIRTHPLACE STATE OR FOREIGN COUNTRY N.J.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH WORCESTER MD.													
10. CITY OR TOWN OF DEATH BERLIN		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) BUMPOINTER RD.		12a. USUAL OCCUPATION RESTAURANT		12b. KIND OF BUSINESS OR INDUSTRY FOOD													
13a. STATE MO		13b. COUNTY COOR		13c. CITY OR TOWN BERLIN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE BUM PINTER RD 21811											
14. FATHER'S NAME WILLIAM		MIDDLE LAST WHEATON		15. MOTHER'S MAIDEN NAME HELEN DEY															
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? YES		16b. SOCIAL SECURITY NO. 48-46-5232		17. INFORMANT CAROLYN WHEATON BERLIN		ADDRESS													
18. CAUSE OF DEATH (Enter only one cause per line 18a, 18b, and 18c) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH year							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.																			
(b) Congestive Cardiomyopathy												year							
(c)																			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?											
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)															
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN			COUNTY			STATE							
21g. I certify that (I) (this hospital) attended the deceased from Nov 29, 1985, to Dec 19, 1985, that (I) (we) last saw the deceased alive on above, (I) (we) (did) (did not) view the body after death.																			
22b. SIGNATURE John S. Green		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/>		MEDICAL DIRECTOR <input type="checkbox"/>		STAFF PHYSICIAN <input type="checkbox"/>		22e. DATE SIGNED 11/21/85									
22d. PHYSICIAN'S NAME (TYPE OR PRINT) J. S. Green		22e. ADDRESS Locast & Queen St 50100, MD																	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 11-23-85		23c. NAME OF CEMETERY OR CREMATORIES DELMARIA CREM		23d. LOCATION CITY OR TOWN LAMES, SUSSEX, DEL		COUNTY		STATE									
24. FUNERAL DIRECTOR NAME ULRICH F.H. Berlin, Md.		ADDRESS		25a. DATE REC'D. BY REGISTRAR NOV 26 1985		25b. REGISTRAR'S SIGNATURE													

